

February 6, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0576-01-SS  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed DO with a specialty and board certification in Neurological Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

This patient is a 64-year-old female who was originally injured in \_\_\_ while lifting at work. She has undergone several decompressive laminectomies of the low back area and appears to have undergone from L2, 3 and 4 levels, although there is some question about the numbering on these multiple scans.

She presents with continued left leg pain and numbness. She also has a history of diabetes.

Electrical studies have shown polyneuropathy secondary to her diabetes and also an S1 radiculopathy on the left. She has had numerous epidural steroid with occasional relief, but no long lasting relief.

#### REQUESTED SERVICE

A request has been made for a spinal decompression at the L4/5 level.

#### DECISION

The reviewer agrees with the prior adverse determination.

## BASIS FOR THE DECISION

Recent MRIs and myelogram CT scans suggest prior surgical interventions at multiple levels. On myelogram CT, there are no areas of significant nerve root entrapment that are focal in nature noted on the myelogram CT scan.

\_\_\_ reports on 9/18/02 that there is some relative spinal stenosis at L3/4 and L4/5. There are areas where the nerve roots are in relatively stenotic areas, but no obvious areas of nerve root compression. The most likely candidate for symptoms in the left lower extremity would be L4/5.

There is no adequate documentation of significant nerve root compression at the L4/5 level that would be addressed appropriately by a decompression at that level. There is inadequate documentation in this chart to confirm whether spinal decompression at L4/5 would be of any benefit to this diabetic patient who has had multiple lumbar back surgeries in the past.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 6th day of February, 2003.**